

Wisconsin Department of Safety and Professional Services

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Madison, WI 53708-8935

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1400 E. Washington Avenue
Madison, WI 53703

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Website: <http://dsps.wi.gov>

DIVISION OF PROFESSIONAL CREDENTIAL PROCESSING

APPLICATION FOR MUSIC, ART OR DANCE THERAPIST REGISTRATION

Under Wisconsin law, the Department must deny your application if you are liable for delinquent state taxes or child support (sec. 440.12, Stats.).

PLEASE TYPE OR PRINT IN INK

☐

Your name and address are available to the public.

Check box to withhold street address/PO Box number from lists of 10 or more credential holders (Wis. Stat. § 440.14)

Last Name

First Name

MI

Former / Maiden Name(s)

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth

Daytime Telephone Number

month

day

year

() -

Ethnic/gender status
information is optional.

Sex:

☐ M
☐ F

Ethnic:

☐ White, not of Hispanic origin
☐ Black, not of Hispanic origin
☐ Hispanic☐ American Indian or Alaskan
☐ Asian or Pacific Islander
☐ Other

PLEASE CHECK THE ORGANIZATION UNDER WHICH YOU ARE CERTIFIED, REGISTERED OR ACCREDITED.

☐

Certification Board for Music Therapists

Credential #

☐

National Music Therapy Registry

Credential #

☐

American Music Therapy Association

Credential #

☐

Art Therapy Credentials Board

Credential #

☐

American Dance Therapy Association

Credential #

☐

Other: _____

Credential #

APPLICATION FEES Make check payable to Department of
Safety and Professional Services and
attach to application.

For Receipting Use Only

_____ **\$75.00 Registration Fee**

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ANSWER THE FOLLOWING QUESTIONS: (Attach additional sheets if necessary.)

- | | <u>YES</u> | <u>NO</u> |
|---|--------------------------|--------------------------|
| 1. Do you have any felony or misdemeanor charges pending against you? If yes, attach Form #2252, Convictions and Pending Charges, providing details about the pending charge, copy of the court documents and status of the charge. [Please do not give details on minor traffic charges, but do include information relating to <u>Driving While Intoxicated</u> (DWI) charges.] | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been convicted of a misdemeanor or a felony? If yes, attach Form #2252 providing details about the crime, including date of conviction, penalty and a copy of the court documents. [Please do not give details on minor traffic convictions, but do include information relating to <u>Driving While Intoxicated</u> (DWI) charges.] | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you incarcerated, on probation or on parole for any conviction? If applicable, attach Form #2252 providing details including the terms of incarceration and a copy of a report from your probation or parole officer. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what state(s). | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under. | <input type="checkbox"/> | <input type="checkbox"/> |

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice music, art or dance therapy" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate assessments and exercise reasoned music, art or dance therapist judgments and to learn and keep abreast of music, art or dance therapy developments; and
2. The ability to communicate those judgments and music, art or dance therapy information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform music, art or dance therapy, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding, the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years**.

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

- | | <u>YES</u> | <u>NO</u> |
|--|--------------------------|--------------------------|
| 6. Do you have a medical condition which in any way impairs or limits your ability to practice music, art or dance therapy with reasonable skill and safety? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Does your use of chemical substance(s) in any way impair or limit your ability to practice music, art or dance therapy with reasonable skill and safety? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |

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- | | <u>YES</u> | <u>NO</u> |
|--|--------------------------|--------------------------|
| 8. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Are you currently engaged in the illegal use of controlled dangerous substances? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |

ALL APPLICANTS MUST COMPLETE THIS SECTION

CERTIFICATION OF LEGAL STATUS.

I declare under penalty of law that I am (check one):

_____ a citizen or national of the United States, or

_____ a qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at <http://www.uscis.gov>.

AFFIDAVIT OF APPLICANT

I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of a credential may result in credential application processing delays; denial, revocation, suspension or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a credential, or renewal or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause for disciplinary action.

Signature of Applicant

Date

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SOCIAL SECURITY NUMBER. Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.¹ A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

First Name	Middle Initial	Last Name
Profession		
Date of Birth	_____	_____
	month	day
		year

$$\begin{array}{|c|c|c|} \hline & & \\ \hline \end{array} - \begin{array}{|c|c|} \hline & \\ \hline \end{array} - \begin{array}{|c|c|c|c|} \hline & & & \\ \hline \end{array}$$

Social Security Number or FEIN

The Department may not disclose the social security number collected above except to the Department of Children and Families for purposes of administering the child and spousal support program,² to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,³ and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.⁴

EMAIL ADDRESS:

Do you have an email address? ☐ Yes ☐ No

If yes, this field is required to receive your application status electronically. Your email address must be clearly legible with the correct case sensitive information.

EMAIL ADDRESS: Submit your email address in the spaces provided below or attach a printer copy.

[illegible]

If no, your checklist will be sent by first class mail.

¹ Section 440.03 (11m), Wis. Stats.

² Sections 49.22, and 440.13, Wis. Stats.

³ Section 440.12, Wis. Stats.

⁴ Health Insurance Portability and Accountability Act (HIPAA) of 1996

This form is authorized by secs. 440.12 and 440.14, Wis. Stats. Making a false statement in connection with this application may result in revocation or denial.